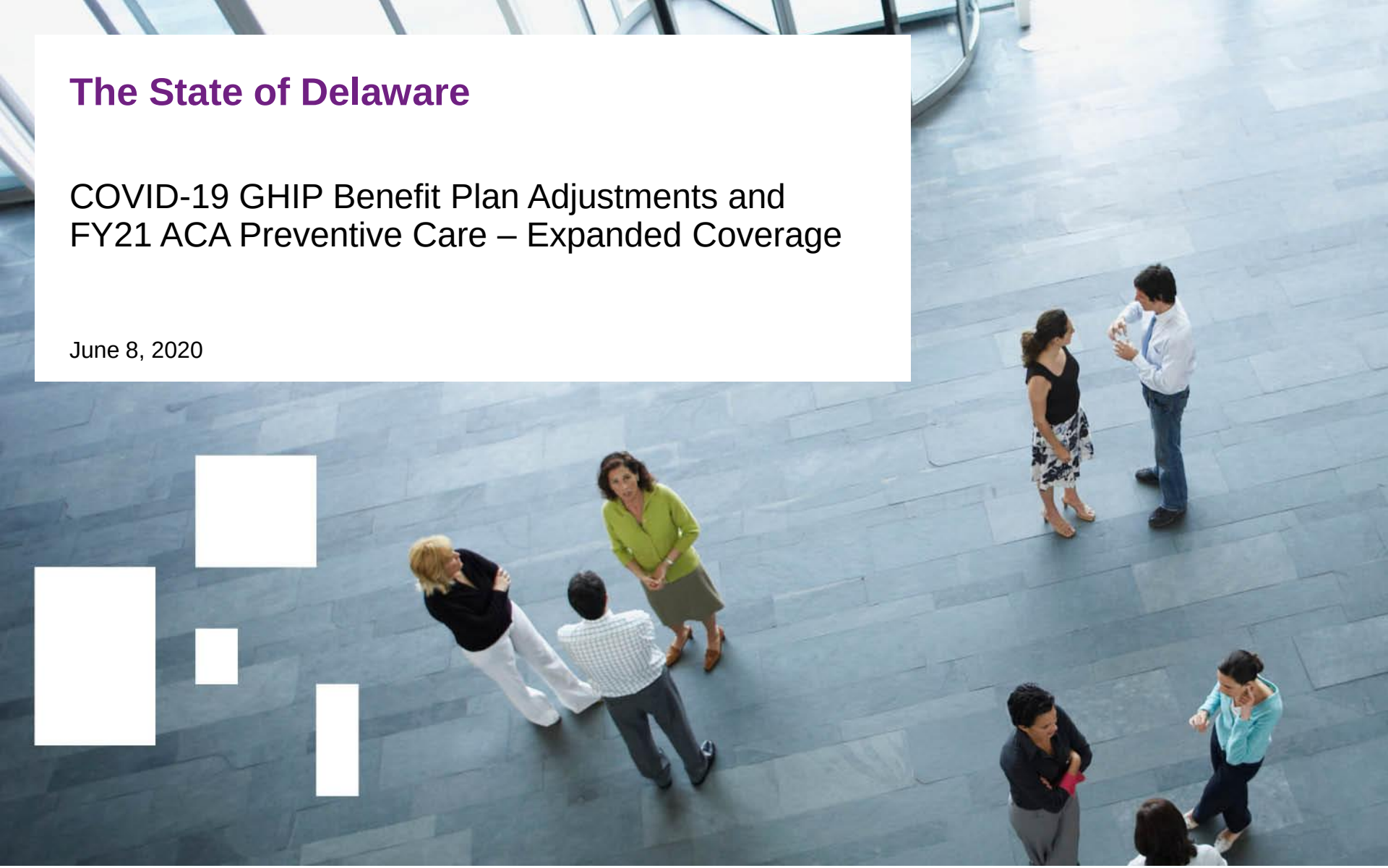
The State of Delaware

COVID-19 GHIP Benefit Plan Adjustments and FY21 ACA Preventive Care – Expanded Coverage

June 8, 2020



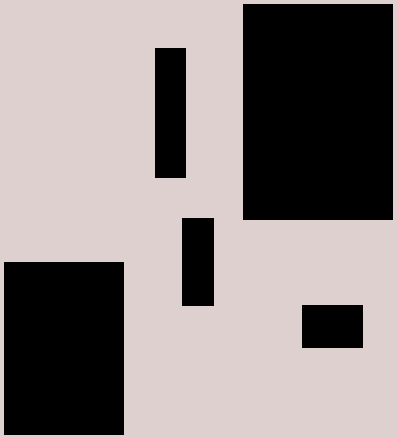
Willis Towers Watson

Today's discussion

- COVID-19 benefit plan changes and related considerations
  - Modified end date recommendations
  - New for SEBC consideration
  - Additional issues related to COVID-19
  - COVID-19 financial impact
- Other benefit plan changes for FY21
  - Recommended for SEBC consideration
  - Potential changes for mid-FY21 implementation
- ACA preventive schedule changes
- Next steps

- Appendix

COVID-19 benefit plan changes and related considerations



COVID-19 benefit plan changes

Modified end date recommendations

Benefit Plan	Change	Optional / Legislation	FY20 Cost	Approval Date for Change	Start Date	Initial End Date	Extended End Date	Recommended Extension?
Medical	No member cost share for COVID-19 testing	FFCRA[1]	-	3/6/2020	3/6/2020[2]	End of federal mandate		N/A
EAP	Coverage for all SOD employees	Optional	$16,800	3/18/2020	3/19/2020	6/30/2020	—	Yes (1)
Medical	No member cost share for office visits (PCP, urgent care, ER) that result in either order or administration of COVID-19 test or for treatment of COVID-19 or associated health complications	FFCRA	—[3]	3/18/2020	3/18/2020	End of federal mandate	9/30/2020 – Aetna & Highmark	Yes (2)
Medical	No member cost share for any telehealth visits	Optional	$25,000 - $37,000 (est.)	3/20/2020	3/20/2020	6/4/2020 – Aetna 6/15/2020 – Highmark	9/30/2020 –Aetna (behavioral and mental health visits only) & Highmark (all telehealth)	Yes (3)

1) Recommend extending for all State employees through 9/30/2020
2) Recommend extending for all members, across both Aetna and Highmark, through 9/30/2020
3) Recommend extending for all members, across both Aetna and Highmark, for all services (not only behavioral and mental health visits), through 9/30/2020 (additional FY21 cost: $25,000 - $37,000)

1 FFCRA = Families First Coronavirus Response Act.
2 FFCRA effective date for covering COVID-19 testing 100% was 3/18/2020; adoption of earlier start date was optional; GHIP elected to begin 100% coverage on 3/6/2020.
3 Not valued separately – cost included in medical estimate for expanding in-network inpatient treatment of COVID-19 on next page.

COVID-19 benefit plan changes

Modified end date recommendations

Benefit Plan	Change	Optional / Legislation	FY20 Cost	Approval Date for Change	Start Date	Initial End Date	Extended End Date	Recommended Extension?
FSA	OTC drugs and menstrual care products are qualifying expenses	CARES Act[1]	N/A	3/27/2020	1/1/2020 (retroactive)	N/A	—	N/A
Medical	No member cost share for in-network, inpatient services related to treatment of COVID-19 or associated complications	Optional	$0.2m-$0.3m[2]	4/2/2020	4/2/2020	5/31/2020 - Highmark 6/1/2020 - Aetna	9/30/2020 – Highmark & Aetna	Yes (1)
Disability Insurance Program (DIP)	Employees reaching STD max duration will remain active in PHRST but will receive 60% LTD and 15% salary supplement in cases where procedures / services related to disability cannot be obtained or employee cannot return to work	Governor's State of Emergency Declaration (12th modification[3])	—[4]	4/23/2020	4/23/2020	12/30/2020	—	No
FSA	Extend timeframe for incurring claims until 12/31/20 for 2020 Short Plan Year	IRS Notice 20-29	N/A	5/12/2020	9/15/2020	12/31/2020	—	N/A

1) Recommend extending for all members, across both Aetna and Highmark, through 9/30/2020 (additional FY21 cost: $0.2m - $0.3m)

1 CARES Act = Coronavirus Aid, Relief and Economic Security Act.
2 Based on estimated annual cost of $0.7m - $1.2m calculated for all medical plans, adjusted for 3 months of FY20.
3 Issued on April 23, 2020. Source: https://governor.delaware.gov/health-soe/twelfth-state-of-emergency/ (Accessed 5/27/2020).
4 No cost to Health Fund; applicable period for disability is claims with start dates between 10/1/2019 and 12/30/2020.

COVID-19 benefit plan changes

New for SEBC consideration

Benefit Plan	Change	Optional / Legislation	FY20 Cost	Approval Date for Change	Start Date	Initial End Date	Extended End Date	Recommended for Adoption?
FSA	Extend timeframe for incurring claims until 12/31/20 for 2019 Calendar Year plan year	IRS Notice 20-29	N/A	**Requires SEBC Vote**	3/15/2020	12/31/2020	—	No (1)
FSA	Allow for prospective mid-year changes without QE	IRS Notice 20-29	N/A	**Requires SEBC Vote**	Date of approval	12/31/2020	—	Not immediately, though see (2)
Medical	No member cost share for COVID-19 vaccine	FFCRA	Unknown	TBD once vaccine is available	Unknown	N/A	—	N/A
Medical	Adopt SilverCloud program (via ESI) that offers additional digital solutions offering support programs on resilience, sleep issues & stress	Optional	N/A	**Requires SEBC Vote**	Date of approval	7/31/2020 (end of free trial period)	—	Yes
N/A	Addition of Rethink work/life resources to help parents/caregivers of children cope with continuing education, behavioral management, and routine adherence while at home	Optional	N/A	**Requires SEBC Vote**	Date of approval	12/31/2020	—	Yes (3)

1) National emergency declaration went into effect on 3/13/2020, only two (2) days prior to end of grace period for 2019 FSA plan year. Plan year reversions are used to pay administrative expenses for the FSA plan and health care FSA reimbursements made to employees who terminate prior to meeting their FSA plan year contributions.

2) This is an optional change in FSA plan rules allowed under IRS Notice 20-29. While the State's next FSA plan year will begin on 7/1/2020, the SBO will continue to evaluate whether there may be a future benefit to plan participants if the State were to avail itself of this option.

3) Free trial period offered by Rethink runs through December 31, 2020.

Additional issues related to COVID-19

- Additional issues, which may need to be evaluated further and potentially addressed depending upon how the pandemic continues to evolve, include:
  - Expanding qualifying events for spouses and coverage of spouses
  - Maintaining benefit eligibility for employee with reduced hours
  - Maintaining benefit eligibility when in “no pay” status
  - Allowing no waiting period for healthcare for essential employees
  - Allowing no waiting period for employees who are laid off or furloughed (without benefits) upon return to work/rehire
  - Extend benefit coverage for leave of absence, furlough, layoff (COBRA look-alike)
  - Premium payment flexibility; relax rules for termination due to non-payment
- SBO/WTW will continue to monitor need for discussion on these items and will plan as needed to review with the Health Policy & Planning Subcommittee before bringing any recommendations to the SEBC

Additional issues related to COVID-19

Regulatory changes to plan administration timeframes

- On April 28, 2020, the federal government issued regulations extending certain plan administration timeframes for group health plans, disability plans and other welfare plans affected by COVID-19
- Extensions apply to deadlines affecting COBRA continuation coverage, HIPAA special enrollment periods, claims for benefits, appeals of denied claims, and external review of certain claims (see Appendix for further details)
- The extension of timeframes under the regulations is effective from March 1, 2020 until 60 days after the announced end of the national emergency as a result of COVID-19

COVID-19 financial impact

Impact of deferred care

- Through May, the impact of deferred care significantly outweighs COVID-19 related plan expenses
  - As a result, the GHIP will generate a significant FY20 surplus
  - The extent and timing of the return of deferred care is largely unknown and will also vary by service category
- The table below highlights the impact of actual medical/Rx claims relative to budget since the onset of COVID-19[1]:

	March			April			May		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual[2]	Budget	Variance
Medical	$51.1m	$48.2m	**+$2.9m**	$44.3m	$61.2m	**($16.9m)**	$32.7m	$54.5m	**($21.7m)**
Rx	$25.3m	$21.5m	**+$3.7m**	$23.6m	$21.8m	**+$1.7m**	$22.7m	$21.8m	**+$0.9m**
Total	$76.4m	$69.8m	**+$6.6m**	$67.9m	$83.0m	**($15.1m)**	$55.5m	$76.3m	**($20.8m)**

  - April/May medical claims are a combined $38.7m below FY20 budgeted amounts
  - April/May Rx claims continue to exceed budget, but variance has declined from March peak

1 Final figures have been rounded to the nearest $0.1m; numbers in table may not add up due to rounding.
2 May actual claims experience is estimated based on weekly claims analysis provided by DHR; actual may vary from final amounts to be reflected in May Fund Equity Report

COVID-19 financial impact

Cost of COVID-19 testing and treatment

- Aetna and Highmark have been tracking weekly COVID-19 related plan expenses; the tables below highlight GHIP COVID-19 expenses based on the most recent weekly dashboards for each vendor:

Highmark YTD COVID-19 Dashboard Summary[1]	
Confirmed Member Count	211
Tested Member Count	1,120
Confirmed Paid Claims	$1.6m
Tested Paid Claims	$0.7m
Pending Charges	$1.9m
Telemedicine Visits (COVID-19)	112
Telemedicine Paid Claims (COVID-19)	$10k

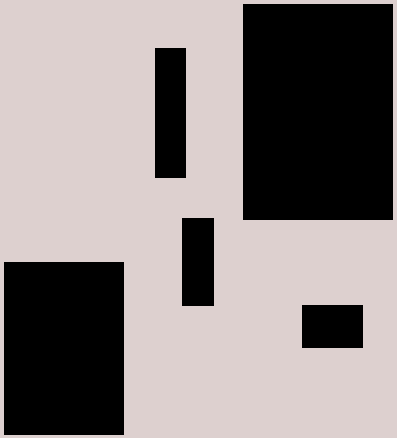
Aetna YTD COVID-19 Dashboard Summary[2]	
# of Claims (Non-Tests)	409
# of Claims (Tests)	589
Adjudicated Amount (Non-Tests)	$84k
Adjudicated Amount (Tests)	$47k
Telemedicine Claims (COVID-19)	124
Telemedicine Paid Claims (COVID-19)	$6k
Telemedicine Claims (Non-COVID-19)	8,526
Telemedicine Paid Claims (Non-COVID-19)	$645k

- COVID-19 testing, treatment and provider billing is still evolving; the information included in these dashboards is believed to be accurate based on all known information as of the production date; however, it is subject to change

1 Covers claims incurred and processed 1/1/2020 – 5/30/2020; tested and confirmed cases are mutually exclusive; pending claims as of 6/1/2020 and represent claims that have been received but not yet adjudicated (claims may be paid or denied and are subject to the member's benefit and contract provisions in force at the time); confirmed cases are identified by the CDC guidelines; tested cases encompass ONLY the members who have been tested but have NOT been confirmed as positive via a claim; telemedicine claims include American Well as well as other providers

2 Covers claims from 3/1/2020 to 5/24/2020; test and non-test cases based on diagnosis and procedure code definitions used for COVID-19 identification; telemedicine claims include Teladoc as well as community based providers performing telemedicine services

Other benefit plan changes for FY21



Other benefit plan changes for FY21

Recommended for SEBC consideration

- The following programs / changes are recommended for the SEBC's consideration to enhance the medical plans for the FY21 plan year
  - Some of these recommendations align with efforts to support members during the COVID-19 outbreak and recognize the greater need for virtual services in the near future
  - These are not intended to drive savings, but instead enhance member access to covered services
  - However, the Retrofit program may produce modest savings, as observed in the Highmark plans

Medical TPA / Plan Options	Program Name & Brief Description	Optional / Legislation	FY21 Cost	Proposed Effective Date
Highmark PPO & First State Basic	**Bright Heart Health (via partnership with Highmark)** ▪ Nationally recognized telemedicine service offering virtual comprehensive addiction treatment 24-7-365	Optional	No additional administrative cost; nominal additional claim cost	7/1/2020
Aetna HMO & CDH Gold	**Tele-Behavioral Health through Teladoc** ▪ Expanded access to behavioral health treatment through Teladoc (similar telehealth capability already in place for Highmark members with Amwell)	Optional	$100,000 - $140,000 (estimated)[1]	7/1/2020
Aetna HMO & CDH Gold	**Retrofit (via partnership with Aetna)** ▪ Virtual diabetes prevention program (already in place for Highmark members)	Optional	$40,000 (estimated)[2]	7/1/2020
Total cost for FY21 – other medical plan changes			**$140,000 - $180,000 (estimated)**	

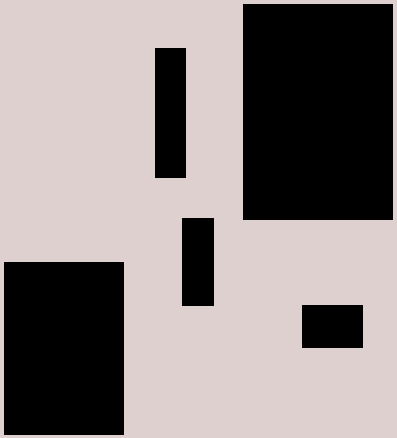
1 Includes $24,000 in administrative fees and estimated claim costs ranging from $72,000 - $113,000 (estimate provided by Aetna), rounded to nearest $10,000.
2 Based on estimated participation rate of 0.2% of Aetna plan participants (similar to Highmark plan participation rate) and assumes all participants enroll in the program on 7/1/2020. Program fees are $59 per participant per month (PPPM) for the first 12 months, then reduce to $29 PPPM starting in the 13th month of enrollment.

Other benefit plan changes for FY21

Potential changes for mid-FY21 implementation

- SBO and WTW are considering other medical program enhancements for a potential mid-year implementation during FY21, including:
  - Leverage SurgeryPlus benefit design to further encourage utilization of this program for elective procedures (improves population health outcomes and furthers cost management for both members and the State)
  - Programs offering targeted support for members with musculoskeletal issues
  - Programs offering additional support for members' mental/behavioral health
  - Programs that steer plan participants to freestanding radiology centers and/or provide more favorable pricing compared to current state
- SBO/WTW will plan as needed to review these further with the Health Policy & Planning Subcommittee before bringing any recommendations to the SEBC
- Additionally, the SBO is evaluating changes to the GHIP Eligibility & Enrollment rules
  - Targeting August 2020 for review with Health Policy & Planning Subcommittee

ACA preventive schedule changes



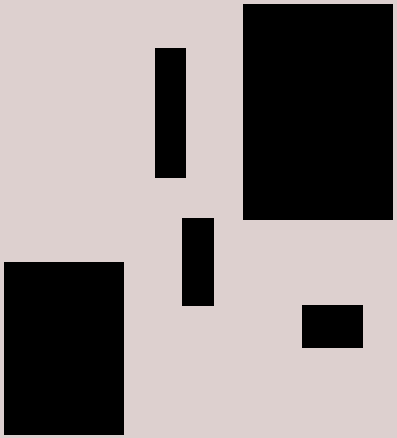
ACA preventive schedule changes

- The following enhancements to preventive care coverage under the GHIP medical plan are required by the Affordable Care Act (ACA) and will take effect during FY21

Preventive Service	Brief Description & Plans Affected	FY21 Cost[2]	Required Effective Date
BRCA[1] Risk Assessment & Genetic Testing / Counseling	Preventive coverage of BRCA risk assessment independent of generic counseling (typically conducted/billed together) as a standalone service (currently covered when coupled with BRCA genetic testing/counseling) across all medical plans.	Nominal	8/1/2020
HPV Vaccine *(expanded coverage)*	Prompted by the CDC's Advisory Committee for Immunization Practices (ACIP) updating recommended HPV vaccination guidelines (prior guidelines covered females through age 26 and males through age 21 [Aetna opted to cover males through age 26]). Required change will standardize GHIP coverage across all plans by expanding coverage as follows: ▪ Highmark – for males aged 22-26 and all participants aged 27-45. ▪ Aetna – for all participants aged 27-45.	$3.9m - $5.9m (estimated)[3]	8/1/2020
Hepatitis C Screening	Expand screening as preventive to adults aged 18-79 (all medical plans)	$0.4m (estimated)[4]	3/1/2021
Total cost for FY21 – ACA preventive schedule changes		**$4.3m - $6.3m (estimated)**	

1 BRCA = BReast CAncer gene; risk assessment estimates a woman's risk of developing invasive breast cancer based on medical and family history.
2 FY21 cost to the GHIP assumes 100% coverage with no member cost sharing when preventive care is provided by an in-network (participating) provider.
3 Based on estimated annual cost of $4.2m-$6.4m for Highmark members, $13,165 for Aetna HMO members and $2,159 for CDH Gold members (estimated costs provided by Highmark and Aetna), adjusted for mid-year implementation (11 months of FY21).
4 Based on estimated annual cost of $740,000 for Highmark members, $269,171 for Aetna HMO members and $41,735 for CDH Gold members (estimated costs provided by Highmark and Aetna) , adjusted for mid-year implementation (4 months of FY21).

Next steps



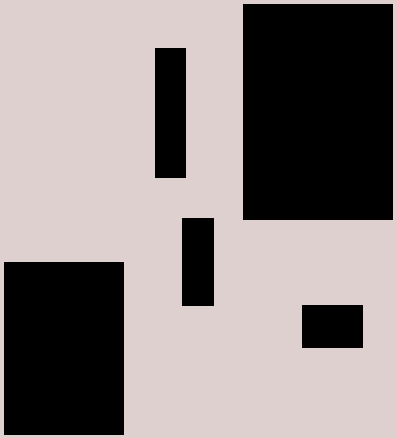
Next steps

- SEBC to vote on extension and/or adoption of recommended changes for FY20 and FY21
- Recommended changes:
  - Extend EAP coverage for all State employees through 9/30/2020
  - Extend no member cost share for IP/OP admissions related to COVID-19, or office visits (PCP, urgent care, ER) that result in order or administration of COVID-19 test for all members through 9/30/2020
  - Extend no member cost share for any telehealth visits through 9/30/2020
  - Extend no member cost share for in-network, inpatient services related to COVID-19 through 9/30/2020
  - Adopt SilverCloud program (via ESI) that offers additional digital solutions offering support programs on resilience, sleep issues & stress
  - Adopt Rethink work/life resources to help parents/caregivers of children cope with continuing education, behavioral management, and routine adherence while at home

Next steps (continued)

- Optional programs requiring SEBC vote for 7/1/2020 effective date:
  - Highmark:
    - Bright Heart Health solution
  - Aetna:
    - Tele-behavioral health expanded access through Teladoc
    - Retrofit virtual diabetes prevention program
- The medical plans will be required to adopt the ACA preventive schedule changes outlined herein, including BRCA risk assessment, HPV vaccine expanded coverage, Hepatitis C expanded screening
- SBO and WTW to continue monitoring:
  - Need for additional changes related to COVID-19, and
  - Feasibility of additional program changes/enhancements for mid-year FY21

Appendix



Regulatory changes to plan administration timeframes

Details on plan administration timeframes affected

All group health plans, disability and other employee welfare benefit plans subject to ERISA or the Internal Revenue Code ("the Code") *must disregard* the following timeframes from March 1, 2020 until 60 days after the announced end of the national emergency as a result of COVID-19:

HIPAA Special Enrollment Periods

- The 30-day period to request special enrollment
- The 60-day period for those who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs

COBRA

- The 60-day election period for COBRA continuation coverage
- The date for making COBRA premium payments (typically 45 days for the initial premium and made not later than 30 days after the first day of the period for which payment is being made for subsequent premiums)
- The date for individuals to notify a group health plan of a qualifying event or determination of disability under COBRA
- The date for providing a COBRA election notice under ERISA and the Code:
  - Generally, an employer has 30 days from the loss of group health plan coverage to notify the plan administrator and the plan administrator then has 14 days to provide a COBRA election notice to the qualified beneficiary
  - Note: while the regulations allow for the extension, it is generally recommended that employers who have terminated employment or reduced hours of employees that result in a cessation of group health plan coverage consider providing the appropriate notices within the normal statutory time frames, if possible, instead of the extended time frames in order to make continued coverage available to those employees ASAP and so employees can elect and start paying for COBRA coverage before they may owe multiple months of back premiums.

Regulatory changes to plan administration timeframes

Details on plan administration timeframes affected

All group health plans, disability and other employee welfare benefit plans subject to ERISA or the Internal Revenue Code ("the Code") *must disregard* the following timeframes from March 1, 2020 until 60 days after the announced end of the national emergency as a result of COVID-19:

Claims Procedures

- The date within which individuals may file a benefit claim under a plan's ERISA claims procedures
- The date within which claimants may file an appeal under a plan's ERISA claims procedures

External Review Process

- The date within which claimants may file a request for an external review under a group health plan
- The date within which a claimant may file information to substantiate a request for external review if the initial request was not complete